Assisted Suicide: Can We Learn from Germany?

by Margaret P. Battin

As the United States' public discussion of euthanasia and assisted suicide grows increasingly volatile, our interest in the Netherlands—the only country that openly permits the practice of euthanasia—has grown enormously. How do they do it? we ask. What drugs do they use? How many cases of euthanasia are performed in a year? Is there abuse? In asking these questions, and in listening to the legions of bioethicists and reporters and concerned physicians who have been to the Netherlands to scrutinize this practice, we are in effect regarding the Netherlands as a kind of natural laboratory for our own possible experiments in right-to-die legislation. Should we legalize euthanasia, as was on the ballot in the state of Washington in 1991 and is proposed for the ballot in California in 1992? Let us look to the Netherlands, we say.[1] Of course, examining euthanasia in the Netherlands has led to considerable controversy about just what is to be observed there—some claim there is virtually no abuse, others insist abuse is widespread[2]—and about the degree to which what we learn can be translated to the U.S., given differences in law, health care systems and other social factors,[3] but all parties seem to agree that whatever is happening in Holland, it has important lessons for us.

However, voluntary active euthanasia is not the only form of aid-in-dying on the ballot in the United States. Initiative 119 and the proposed California legislation would also legalize physician-assisted suicide. Yet although the Netherlands also now tolerates physician-assisted suicide under the same legal device that it tolerates euthanasia, the rates of practice are quite different: while about 1.8 percent of all deaths in the Netherlands are the result of euthanasia, only about 0.3 percent involve physician-assisted suicide.[4] It is euthanasia in the Netherlands that has attracted the world's notice; assisted suicide has played only a very minor supporting role.

Yet in the United States, there seems to be nearly as much—or perhaps more—public sympathy for assisted suicide as for active euthanasia. In a *Boston Globe*/Harvard survey of U.S. attitudes toward death and dying taken in October 1991, for example, 54 percent of a national sample of 1,311 adults over age eighteen said that if they had an illness with no hope of recovery and were suffering a great deal of physical pain, they would or probably would consider asking their doctor to administer lethal drugs or a lethal injection; and 53 percent said that in the same circumstances they would or probably would ask their doctor to prescribe a lethal drug that they could decide to take later on.[5] Significantly, the opposition to Initiative 119 in the state of Washington focused almost exclusively on the dangers of euthanasia, not assisted suicide: prevent "medical homicide," was the cry,[6] but little was said about restricting a patient's freedom to choose suicide—which, in Washington as in almost all other states, is not illegal. Given the currently chaotic and increasingly callous nature of health care financing in the United States, preferring assisted suicide to active euthanasia is not, I think, an unrealistic position. Because the U.S. is so sensitive (as it should be) to the risks of abuse, and because permitting assisted suicide would require a less dramatic change in the law, I think that the United States will come to accept assisted suicide in the relatively near future, officially as well as tacitly, but is likely to resist legalizing active euthanasia for a longer time.

But if this is so, then there is something ironic about turning only to the Netherlands for insight into issues of aid-in-dying: the Netherlands evidently prefers euthanasia to assisted suicide. What lessons can we learn from a country that sees things the other way around? Germany openly permits the practice of assisted suicide, but rejects euthanasia. Thus it is in a sense the obverse of the Netherlands; hence despite many other differences, the lessons to be learned here should be at least equally, or perhaps more, instructive for us.

That the Germans view aid-in-dying issues differently from the Dutch is little surprise, given their quite opposite histories in the Second World War. In the minds of most Germans, the very term *euthanasia* is associated with the Nazis, and, in general, it is understood as involuntary killing on potentially political rather than medical grounds. Rejection of euthanasia may also be associated with distrust of physicians in an authoritarian medical climate. To be sure, since the mid-1980s there has been some renewed discussion among bioethicists of voluntary active euthanasia, but recently even the very discussion of it has been vigorously combatted by a coalition of protest groups. They claim that even to speak of euthanasia is to legitimate it; speeches have been silenced and entire conferences driven out of the country to prevent the raising of this issue.[7] For a complex set of reasons, however, attitudes toward assisted suicide are conceptually different from attitudes toward euthanasia, and unlike the U.S. and Holland assisted suicide is not regarded simply as a variant of euthanasia differing primarily in who delivers the fatal dose.

The situation with respect to assisted suicide in Germany is marked by two important features. For one thing, the practice is both legal and partly institutionalized; it occurs on a much larger scale and in different ways than in Holland, and of course occurs in a way not currently possible in the United States. Second, the practice of assisted suicide in Germany is embedded in a distinc-

Margaret P. Battin *is professor of philosophy at the University of Utah, Salt Lake City, Utah.*

tive cultural climate, especially concerning the background conception of suicide; its features can best be made evident by looking at linguistic differences between German and English. Not only do patients with terminal illnesses have different options concerning suicide in Germany than they do in the U.S.; they are also able to talk differently about it and presumably think differently about it as well. The two main parts of this paper will address these two principal concerns.

The Character of German Medicine

At least in what was formerly West Germany, medicine is technologically advanced, and, under a complex national health insurance system, provides a high level of care to virtually all inhabitants. Like the United States, Germany has entered the most advanced stage of what is known as the epidemiological transition, and the majority of deaths no longer occur, as they did in earlier historical periods and still do in the third world, as the result of parasitic or infectious disease, but as the result of advanced deteriorative disease late in life—cancer, heart and other deteriorative organ failure, stroke, neurological diseases, and so on. Like American medicine, German medicine has the capacity to "prolong" the lives of dying patients by means of respiratory, nutritional, and other support, but by no means always does so: a substantial proportion of expected deaths are "negotiated," the result of artful giving up. As in the U.S., in Germany it is also often held appropriate to withhold or withdraw treatment from patients in the late stages of terminal illness, when survival is unlikely and treatment seems only to prolong dying. In this respect, American and German medicine are similar.

However, German medicine is often said to be quite authoritarian. Although empirical data have yet to be published, a large study currently in progress at the University of Göttingen is exploring a number of hypotheses that are often said to characterize medical decisionmaking.[8] These center around the claim that decisionmaking remains largely in the hands of the physician; while consent by the patient is legally required, and indeed consent forms for major procedures are routinely signed, neither patient understanding nor consent are much emphasized. In circumstances in which the patient faces oncoming death, according to the hypotheses of the Göttingen study, it is the physician who makes decisions about the initiation or withdrawal of life-sustaining therapy. In these decisions, the evaluations and views of nurses and other caregivers play a considerable role and consent is for the most part sought from the patient's relatives; however, in most cases the patient, who is often no longer competent, is not included in decisionmaking. Living wills are rarely used; the durable power of attorney has only come into effect as of 1 January 1992. Do-not-resuscitate orders are rarely explicitly executed and only in exceptional cases put in written form; for the most part they are made in agreement with the family but without discussion with the patient. Where they are written at all, DNR orders are only very briefly documented and supported. The wishes of a competent patient are for the most part considered, but only if they are clearly expressed and if the conditions for patient decisions—namely, adequate information and explanation—have been met. However, this is the exception, not the rule. For the most part, there is no such thing as informed consent. In general, decisions about life-sustaining therapy are made by the physician, not the patient, and are consented to by the family. If the physician favors initiating intensive measures and the patient or family do not, the physician's preference for the most part prevails, and while explicit disagreement is rare, where a lucid patient expresses the wish to decline life-prolonging measures, this wish is frequently ignored. The only case, according to the hypotheses of this study, in which patient or family preferences appear to prevail over those of the physician is when the physician opposes initiating intensive measures, but the patient or family demand them.

It is in this medical climate that Germany's distinctive practices concerning suicide in end-of-life situations have begun to develop. For the most part, patients "in the system" of hospital care do not demand or achieve self-determination in matters of dying. However, taking advantage of the legal situation in Germany with respect to suicide, there has developed a substantial movement to avoid such situations altogether. It is led by a large, independent, nongovernmental, and nonmedical organization, the Deutsche Gesellschaft für humanes Sterben (DGHS), or German Society for Humane Dying, which actively supports suicide or assisted suicide as a way of achieving a painless, self-determined death.

Suicide and Euthanasia under German Law

The existence of the DGHS is made possible by a distinctive feature of German law, a feature in which German law differs from that of England, the U.S., the Netherlands, and most of Europe. During the Middle Ages in most of Europe suicide was a felony punishable by desecration of the corpse, burial at a crossroads, forfeiture of the decedent's estate to the crown, and, in some instances, execution if the suicide attempt was not fatal. Suicide was decriminalized in England and Wales only in 1961, primarily for the purpose of permitting medical and psychiatric treatment without criminal onus for those who had attempted suicide. In contrast, suicide was decriminalized in Germany by Frederick the Great in 1751. Assisting suicide is not a crime in Germany either, provided that the person about to commit suicide is *tatherrschaftsfähig*, that is, capable of exercising control over his or her actions, and also that he or she acts out of *freiverantwortliche Wille*, or freely responsible choice.[9] Thus, while assisting the suicide of a disturbed, depressed, or demented person or a person coerced by external forces would not be permitted under German law, aiding an informed, voluntary suicide, including what we might be tempted to call a "rational suicide," is. However, killing upon request—the act involved in euthanasia—is prohibited under German law.

To be sure, the details of German law on these points have been receiving extended discussion, especially with respect to the apparent conflict between the fact that assisted suicide is not illegal but that there may be a duty to rescue a suicide in progress. Like U.S. law, German law imposes an obligation to rescue upon specific parties standing in certain professional or personal rela-

tionships to other persons; this is the basis of the physician's legal duty to rescue his or her patient. Thus, as one widely prevalent interpretation of the legal situation holds, although the physician is not prohibited from giving a lethal drug to a patient, once that patient has taken the drug and becomes unconscious, the physician incurs a duty to resuscitate him or her.[10]

These provisions of German law—all currently highly controversial—have the effect of curtailing the role of German physicians in suicide, and tend to insulate the patient from physician aid. Thus German law reinforces a posture that might also seem to be a product of fear of euthanasia and suspicion of authoritarian physicians: in Germany, taking death into one's own hands in these contexts is an individual, private matter, to be conducted outside the medical establishment and largely without its help. This is not to say that the provisions of German law are the product of studied judicial deliberation or current political consensus; they are often viewed as an artifact of earlier times. In any case, although it apparently would not be illegal for physicians to assist in the initiation of their patients' suicides, as a matter of practice they do not do so. There is some move to suggest that the obligation to rescue extends beyond the physician to a spouse, friend, or any person with knowledge of a suicide in progress, but this is currently an extremely controversial issue in German law.

That neither suicide nor assisted suicide are illegal under German law does not mean that there can be no attempts to prevent suicide. Indeed, Germany has an active organization for suicide prevention, the Deutsche Gesellschaft für Suizidprävention (the German Society for Suicide Prevention), which directs its attention in particular to recognizing suicidal tendencies in disturbed, depressed, or demented persons—that is, persons who cannot be said to be in control of their actions and who are not exhibiting freely responsible choice. Since, of course, it is not always possible to determine in advance whether a given person's suicide might count as in control or not in control, or as the product or not the product of freely reponsible choice, in practice Germany's suicide prevention efforts look very much like those elsewhere, and are generally directed across the board at preventing suicide.[11]

It is in this climate, then—a climate in which there are active programs of suicide prevention, in which suicide and assisted suicide are not illegal, and in which terminal patients have little control within the medical establishment—that the German Society for Humane Dying, the DGHS, has developed. It is not much known in the rest of the world, among other reasons because it has not joined the World Federation of Right-To-Die Societies. This is in part a function of its very different attitudes about the relationship of suicide and euthanasia, explained by the profound mistrust Germans have of euthanasia: the DGHS insists that euthanasia cannot be legalized without *prior* legalization of assisted suicide;[12] the World Federation and the national right-to-die organizations which are its members support the immediate legalization of euthanasia and assisted suicide as well, as would have been the case with the state of Washington's Initiative 119 and the proposed California legislation. In part because the Dutch, American, and most other national right-to-die societies, including the U.S.'s Hemlock Society, see the issue of euthanasia in a way quite opposite from the DGHS, there is little love lost between them, and even in Germany the DGHS remains a highly controversial organization. Nevertheless, the DGHS is a major, functioning organization, and its activities are important to understand for those discussing end-of-life issues in the U.S. and other parts of the world.

The German Society for Humane Dying (DGHS)

Founded in 1980 to facilitate suicide for those who are terminally ill as a way of avoiding the medicalization of the end of life, by September 1991 the DGHS had grown to some 50,000 members, and has been adding new members at the rate of 1,000 per month. Many of its members are already elderly or already terminally ill. After a person has been a member of the organization for at least a year, he or she may request a copy of DGHS's booklet *Menschenwürdiges und selbstverantwortliches Sterben,* or "Dignified and responsible death," which is not commercially available. The DGHS does not charge for this booklet. The booklet itself includes a statement of the conditions under which it is obtainable—including the requirement that the member has not received medical or psychotherapeutic treatment for depression or other psychiatric illness during the last two years. Each copy is numbered; the member is urged to keep track of it, not to give it to third parties, and not to make public its contents in any other way. The booklet is to be returned to DGHS after the member's death. The DGHS reports approximately 2,000 to 3,000 suicides per year among its members.

The specific advice provided in the DGHS's booklet contains, among other things, a list of ten drugs available by prescription in Germany, mostly barbiturates and chloroquines, together with the specific dosages necessary for producing a painless, nonviolent death. (Although the DGHS was originally associated with the provision of cyanide, it no longer recommends this.) In addition to the drugs that will produce death, the booklet lists companion drugs for preventing vomiting and for inducing sedation. It also lists drugs available without prescription in other European countries (some just a few hours drive from parts of Germany), including France, Italy, Spain, Portugal, and Greece. DGHS recommends that the member approach a physician for a prescription for the drug of choice, asking, for example, for a barbiturate to help with sleeping or chloroquine for protection against malaria on a trip to India. Where this deception is difficult or impossible, the DGHS may also arrange for someone to obtain drugs from a country where they are available without prescription. In unusual cases, it will also provide what it calls *Sterbebegleitung* or "accompaniment in dying": this is provided by a companion who will remain with the person during the time that is required for the lethal drug to take full effect, often as much as ten to twelve hours or longer. However, the DGHS now urges that family members or friends, rather than DGHS staff or members, provide "accompaniment," and has recently inaugurated an "Akademie der Sterbebegleitung" or academy of accompaniment in dying to train such persons in what to expect and how to be supportive.

DGHS also supports refusal of treatment, where that is what the patient wishes, and in general attempts to protect a broad range of patients' rights. It provides members with a series of forms, including copies of Germany's version of the living will and durable power of attorney. In the format provided by the DGHS, both of these forms not only stipulate health care choices or persons empowered to make them on behalf of a no-longer-competent patient, but they also include provisions authorizing the DGHS to take legal action against any person or organization (that is, any physician or hospital) that refuses to honor the patient's antecedently stipulated wishes. For those who choose suicide as a way of bringing their lives to an end, the DGHS also provides a form intended to provide clear evidence both of the considered nature of that choice and to dispel any suspicion of foul play. The form—printed on a single sheet of distinctive pink paper—is to be signed once when the person joins the DGHS, asserting that he or she is a member of the organization and that he or she wishes to exercise the right to determine the time of his or her death; the same form is to be signed again at the time of the suicide—presumably, at least a year later—and to be left beside the body.

DGHS also relies heavily on its network of regional bureaus to encourage and facilitate feedback. Since assisting suicide is not illegal in Germany, there is no legal risk for an individual in soliciting information about suicide or in that person's family reporting back information about methods of suicide attempted or used. DGHS attempts to keep very careful track of its members' experiences with the information it provides, and uses this feedback to revise and update its drug recommendations. To facilitate this, the drug information provided in its booklet is printed on a separate sheet inserted in a slip pocket inside the back cover, and this list of current recommendations is revised and updated on a monthly basis. DGHS thus claims to be able to do what is much riskier in countries where assisting suicide is illegal: to make extensive use of feedback about actual methods of suicide. In mid-1991, when the Hemlock Society's president Derek Humphry's book *Final Exit* hit the top of the *New York Times* how-to bestseller list,[13] DGHS president Hans Henning Atrott complained that the American book's information wasn't fully reliable: it was based, Atrott claimed, on published toxicological information, or information about what drug doses *might* prove sufficiently toxic to cause death, and not on empirical information about what drug doses would be *certain* to cause death. Because of the quite different legal situation in Germany, DGHS is able to collect reports about its own members' suicides and thus to adjust its drug recommendations on the basis of actual experience. Humphry replied that he gets just as much information from the 47,000 members of the Hemlock Society, including explicit information about suicide deaths from patients' families, from doctors, and even occasionally from patients whose suicide attempts were not fatal,[14] but it is clear that such information is collected in a very different climate in the U.S. Fearing that they would be subpoenaed, the Hemlock Society was forced several years ago to burn first-person reports from a sizeable number of physicians of cases of euthanasia they had performed or suicide in which they had assisted.

Language and the Cultural Acceptance of Suicide

Beyond doubt, the unique legal situation in Germany contributes to the rather different way in which end-of-life issues are often viewed; so too does the rapid growth of an organization like the DGHS. But there are deeper cultural factors involved, and these are nowhere more evident than in the German language itself.

In current usage, English provides one principal term to denote self-caused death, *suicide*. In contrast to English's primary reliance on a single term, German employs several distinct ones: the traditional terms *Selbstmord* and *Selbsttötung*, the scientific term *Suizid*, and the literary *Freitod*.[15] *Selbstmord* and *Selbsttötung* are the analogues of the English terms *self-murder* (also *self-murther*) and *self-killing*, which were in widespread use in English during the seventeenth and eighteenth centuries; in English these terms were eventually supplanted by the Latin construct *suicide* and have virtually disappeared from contemporary use. The German terms both remain current. The German *Selbstmord*, the term most frequently used in ordinary spoken and written discourse, carries extremely negative connotations, no doubt associated with its literal meaning "self-murder," including the implication of moral wrong. In partial contrast, *Selbsttötung*, literally "self-killing," has connotations that are comparatively neutral in their factual quality but still decidedly negative, just as *killing* is neutral in English compared to *murder* but still decidedly negative. *Selbsttötung* is used primarily in bureaucratic and legal contexts. The German term *Suizid*, the Latinate construct linguistically analogous to the English term *suicide*, also literally means "self-killing" but is comparatively neutral in its moral connotations; instead, it conveys an implication of psychiatric pathology, and is the technical term characteristically used by clinicians and researchers. While these terms are primarily found in their conversational, bureaucratic, and clinical applications respectively, they are also sometimes used interchangeably.

German's fourth term for self-caused death, however, is quite another matter. *Freitod* (literally "free death" or "voluntary death") is a positive term, free from connotations of either moral wrongness or pathology; it also avoids the drabness of bureaucratic facticity. It is associated with voluntary individual choice and the expression of basic, strongly held personal values or ideals, especially those running counter to conventional societal norms, and suggests the triumph of personal integrity in the face of threat or shame. *Freitod* has an archaic flavor, often associated with Romanticism, and would not generally be used in ordinary conversation; however, it is readily recognizable to most speakers. But while the most common term for suicide, *Selbstmord*, and the comparatively uncommon literary one, *Freitod*, both refer to the act of bringing about one's own death, they have very different connotations and describe what are understood to be quite different sorts of acts. *Selbstmord* is taken to involve a generally repugnant, tragic act, generally associated with despair, anger, or depression; *Freitod*, in contrast, is seen as expressing voluntary, idealistic choice.

Even the verbs used with the different German terms for suicide reinforce their semantic differences: one "commits" *Selbstmord* (*man begeht Selbstmord*), but one "chooses" *Freitod* (*man wählt den Freitod*). It is not grammatically possible to speak either of "choosing" *Selbstmord* or of "committing" *Freitod.*

To be sure, both English and German also offer a variety of peripheral terms to refer to suicide—for example, English's *self-destruction* and the archaic *self-slaughter,* German's *Selbstentleibung* (literally, "self-disembodiment"), all terms with strong connotations of violence, as well as an assortment of verbal expressions, many of which appear in similar forms in both English and German: *sich das Leben nehmen* ("take one's own life") and often make reference to the means of death employed: *sich erhängen* ("hang oneself"), *sich erschießen* ("shoot oneself"), *sich ertränken* ("drown oneself"), and so on. But the central contrast lies between English's current reliance on a single principal term, *suicide,* and German's routine use of several different terms, especially *Selbstmord, Selbsttötung, Suizid,* and *Freitod.* Despite its comparative archaism and infrequent usage, this latter term, *Freitod,* plays an especially significant role and is crucial to understanding the nature of institutionalized assisted suicide practices in contemporary Germany.

The term *Freitod* is often thought by educated Germans to date from the eighteenth century, emerging around the same time that Frederick the Great was decriminalizing suicide. The term seems particularly associated with the *Sturm und Drang* or Storm and Stress movement in German literature, especially the plays of Goethe and Schiller—plays read, of course, by German students during their high school years. Perhaps the most familiar, celebrated example of *Freitod* in German literature would be said to be the death of Goethe's character Werther, the hero of his 1774 novella *The Sorrows of Young Werther:* in this compelling tale, a projection of Goethe's own ill-fated love affair with Charlotte Buff, Werther chooses to end his own life rather than sink from a condition of extraordinary sensitivity and sensibility into the respectable tedium of everyday life.[16]

Curiously, however, etymological sources do not actually trace the word *Freitod* as far back as Goethe; rather, they find that it originates with the title of Section 22 of Nietzsche's *Also Sprach Zarathustra* (1883), *Vom Freien Tode* (variously translated "On free death" or "On voluntary death").[17] In this work, Nietzsche develops the notion of *Übermensch* or "superman," a concept later misunderstood and appropriated by National Socialism, and asserts a central teaching of Zarathustra: "Die at the right time." *Meinen Tod lobe ich euch, den freien Tod, der mir kommt, weil ich will,* says Zarathustra—"My death, praise I unto unto me because *I* want it."[18] The death to be avoided is the "common, withered, patient death" of those who are "like sour apples": their lot is to "wait until the last day of autumn: and at the same time they become ripe, yellow, and shrivelled." The death that Zarathustra preaches is an active, extraordinary, heroic death, an earlier, self-willed death of which the ordinary man is hardly capable.

Perhaps because of the association of Nietzsche's *Übermensch* with Nazism, *Freitod* with its quite positive connotations is rarely thought to originate there, and is instead attributed, erroneously, to the pre-Romantic idea. But the term is not found in either Goethe or Schiller, and indeed the single term, *Freitod,* is not even found in Nietzsche, though it originates from Nietzsche's two-word phrase.[19] Yet however problematic its actual origins, the term does have a distinctive, well-recognized sense in contemporary German: although it refers to the act of bringing about one's own death, it does not convey the very negative moral connotations associated with *Selbstmord,* the factual but still negative connotations of *Selbsttötung,* or the pathological ones associated with *Suizid.* On the contrary, the connotations of the term *Freitod* are wholly positive: achieving this kind of death is an admirable, heroic—if very difficult—thing to do.

There is no analogous term in English. While there have been recent attempts at coinages in English (for example, *self-deliverance*) to describe suicide but avoid that term's negative connotations, there is no widely recognized, familiar English term with long historical resonances of the sort that *Freitod* seems to have. The only other English terms for suicide that do not have negative connotations carry either pronounced religious associations or the implication that the suicide serves the interest of some other person or cause: these are terms like *self-sacrifice* and *martyrdom.* The very concept of *Freitod*—a notion without religious, altruistic overtones and without negative moral or psychological implications, but which celebrates the voluntary choice of death as a personal expression of principled idealism—is, in short, linguistically unfamiliar to English speakers. Language is crucial in shaping attitudes about end-of-life practices, and because of the very different lexical resources of English and German, it is clear that English speakers cannot straightforwardly understand the very different German conception of these matters. Even in situations of terminal illness, the very concept of voluntary death resonates differently for the German speaker who conceives of it as *Freitod* than it does for the English-speaker who conceives of it as *suicide.*

Thus, while one sees in both Germany and the U.S. the development of notions of what is often called rational suicide and the conception that this may be a reasonable choice in terminal illness, they occur in very different cultural climates. In an English-speaking country like the United States, in contrast, there is no tradition that recognizes a distinctive sort of suicide, different from immoral or pathological suicide, and no tradition of legal or other protection for it. Not even among the English Romantics is there a literary model quite like Werther, whose death could readily be described as *Freitod.* The sense of the German term *Freitod* is simply not to be found in any single term in English. Furthermore, it could be constructed in English only with comparatively clumsy circumlocutions: "suicide which is self-centered but without the negative connotations of either 'suicide' or 'self-centered'"; "self-deliverance but with long, positive historical resonances," and so on, but these paraphrases would hardly capture the rich connotative field that has developed around the term *Freitod.* This is not to say that German speakers are always actively aware of the history and connotations of *Freitod,* but that the German language provides resources for thinking about, expressing, and experiencing choices about suicide in terminal illness in a way that English does

not. It is tempting to say, then, that these choices themselves may be rather different for the German speaker than the English speaker. If so, it is also plausible to suppose that choices of suicide in terminal illness, protected not only by legal but also by linguistic and hence conceptual supports, may be much easier to make in Germany than they are in the U.S., where legal, linguistic, and conceptual structures all militate against them. Furthermore, presumably, not only may these choices be easier for the German speaker to make, they may also be easier for survivors to accept and for the culture as a whole to acknowledge. Of course, there are factors in German culture that militate against suicide as well—religious sanctions, for example; but the picture may nevertheless be rather different from the one we see in the U.S.

Indeed, the DGHS deliberately exploits the conception of ending one's life in terminal illness as *Freitod* rather than *Selbstmord.* The distinctive pink form mentioned earlier, to be signed when joining the DGHS and to be signed again at the time of one's final act, does not refer to that act as suicide, but as free death: it is labelled *Freitod-Verfügung,* or "free death directive." On the line just prior to the space for the second signature, the form reads: *Ich habe heute meinen Freitod eingeleitet.*—"I have brought about my free death today." This is the form that will be found beside the body. The terms *Selbstmord* and *Suizid* appear nowhere in this document, and the bureaucratic term *Selbsttötung* appears only on the reverse side in the language of quotations from German law about the legal status of suicide.

From Language to Practice

To be sure, many objections can be raised to the conception of suicide that the notion of *Freitod* supports or to its institutionalization in the practices of the DGHS. For example, because the German practice of assisted suicide, as shaped both by law and by linguistic expectation, tends to minimize the role of the physician, it tends as well to minimize the opportunity for whatever evaluation, counseling, and psychiatric consultation the physician might provide. It also leaves to the patient the primary responsibility for deciding whether the physician's diagnosis is accurate and the prognosis realistic, and whether there are other effective methods of treatment or symptom relief. There is little or no role for psychiatrists here, or for any other outside, "objective" evaluation of a patient's mental state. *Freitod* is conceived of as a profoundly individual, private matter, not one subject to external examination, which in any case runs counter to commonplace societal norms. This is not to say that every terminally ill person who commits suicide in Germany conceives of this act as *Freitod* or approximates it to the independent, Romantic/Nietzschean model as an expression of one's basic values, but the likelihood of this is, of course, much greater than in the United States, where an analogous conceptual model is not readily available at all.

Some objections are also raised to the portrayal of suicide in terminal illness as *Freitod* rather than as *Selbstmord, Selbsttötung,* or *Suizid.* For example, in a 1977 discussion of issues in voluntary death, the writer Gabriele Wohmann said she did not like to use the term *Freitod* in these discussions because it is "simply too pretty, too seemingly tasteful."[20] Nor do all discussions of the issue trade on emphasizing the opposition between *Selbstmord* with its highly negative connotations and *Freitod* with its positive ones; many of the academic discussions employ the comparatively neutral term *Selbsttötung* instead,[21] and others attempt to cleanse the usual term *Selbstmord* by rejecting its negative connotations.

Questions can also be raised about the fit between the concept of *Freitod* and the assisted suicide practices possible in contemporary Germany. *Freitod* itself is conceived of as an individual, intensely personal, and thus characteristically solitary act. The word itself does not suggest (as is often the case with euthanasia in Holland) that the period of dying is one in which one might expect to be surrounded by a devoted family or close friends, or supported by a trusted authority such as a priest or doctor. Nor does the German term suggest that one would be guided in one's decision by professionals or family members. It is an act in which one insists on choosing a different, individual course contrary to ordinary expectations: it is in this sense that it is "free" death. This has its advantages: almost by definition, *Freitod* cannot be socially "expected," required by policy, advised by counselors, or in any other way the norm, and hence it may be more resistant to abuse. Yet this does raise the issue of what tensions might arise for the person for whom the rhetoric of *Freitod* seems to describe a choice more individualistic and idealistic than he or she is actually making, or, conversely, what tensions might arise for the person for whom accusations of *Selbstmord* from unsympathetic physicians, family, or religious advisors seem to belittle the personal, reflective nature of his or her final choice. While choices of suicide in terminal illness may be easier to make in a linguistically richer culture than in one that is more limited in its resources for describing this choice, such tensions are no doubt very real. After all, DGHS is an organization that offers membership and provides help with suicide, both in giving information and in training family members or others to be present—and hence in this way the person may be accompanied and not alone—but the linguistic and cultural model to which it appeals is one of solitary, profoundly individual choice.

What, If Anything, Can We Learn from Germany?

As we observe our increasing ferment in the United States over right-to-die issues, we can, I think, predict that of the two forms of aid-in-dying that are the focus of attention in the U.S.—active euthanasia and assisted suicide—it is the latter which will more readily find some degree of social acceptance. This might seem to make the German experience with assisted suicide as much or more relevant to us than the Dutch experience with active euthanasia, and to suggest that we should attend to the ways in which not only Dutch but also German culture has faced such issues. Certainly examining other cultures is an important remedy for our often isolationist myopia about social issues, and certainly observing a culture that has a far more open, widespread practice of assisted suicide in terminal illness will be enormously instructive for us.

What we discover, however, is that the issue is much more difficult than we thought, and that cross-cultural lessons

are harder to draw. For what we see is that we are limited by our own language, and do not have the linguistic resources for understanding the issue in the way members of another culture can. We do not and perhaps cannot fully understand German attitudes towards what *we* call "suicide," and we cannot really comprehend this other way of looking at the issue—even though our cultures, economies, and medical establishments are in many ways very similar. For the German, *Selbstmord, Selbsttötung,* and *Suizid,* those phenomena described in terms with connotations of moral wrongness, bureaucractic factualness, or psychopathology, are of course to be prevented, even though the law neither prohibits them nor prohibits assisting them where they are performed by a person who is in control of his or her actions and acting out of freely responsible choice. On the other hand, the German tends to respect *Freitod,* however difficult it may be to say exactly what differentiates this phenomenon from the previous forms of self-caused death, and tends to regard *Freitod* as a matter of right—that is, to assume that it ought not to be interfered with and that one always has the right to this choice. Thus, it is at best difficult for us in the United States fully to understand how members of German culture see these matters, and it is also difficult to understand what position the German takes himself or herself to be in when reflecting on the prospect of medicalization of the end of life and the alternative of an earlier, self-caused death. Even if we could somehow capture the distinctions a German-speaker senses among the various terms for self-caused death, we could not bring with them the set of background models and the full range of culturally understood connotations. There is no easy English way to convey both what *Freitod* suggests and at the same time avoid what it does not.

If there are distinctions German speakers make but English speakers do not in speaking of what we call suicide, perhaps we English speakers cannot even fully understand our own assumptions and beliefs about these matters. We say we are committed to "preventing suicide," for example, but this may be just to say that we are committed to preventing *Selbstmord, Selbstötung,* and *Suizid.* Are we also committed to preventing *Freitod,* when we cannot distinguish it from these other forms of self-caused death, or on the contrary do we simply lack any reflective, principled view about whether we ought to do so? We cannot easily say whether we ought to prevent it, given our commitment to suicide prevention, because *we cannot even fully conceive of what it is,* and we cannot even say either that it is "a kind of suicide" or that it is not.

That we cannot make this distinction is not to say that we are altogether incapable of making distinctions among accepted, even respected forms of self-caused death and those we reject or consider candidates for prevention. On the contrary, English speakers readily make the closely related distinction noted earlier involving altruistically or religiously motivated self caused death. Typically, English speakers respond with approval, for example, to the jet pilot going down with the plane in order to avoid the crowded schoolyard, but mark the conceptual difference by insisting that "that's not suicide." This is a response analogous to the one German speakers would use to differentiate *Selbstmord* and *Freitod,* but the distinction is not the same one. The distinction between suicide as a moral wrong or psychological aberration and as a religously or altruistically motivated choice is readily marked off in English, but the distinction between suicide as a moral wrong or psychological aberration and an autonomous choice based in personal ideals and values is not.

What practical lessons, then, does this closer examination of assisted-suicide practices in contemporary Germany teach us about the United States, and particularly about the kinds of practices the U.S. should or should not legally recognize, morally recognize, or otherwise adopt? The central issue, it seems to me, has to do with the role of the physician. What is so striking about the German practice is the comparative absence of the physician from the scene; the question for the U.S. is not merely whether the physician ought to play the same absent role, but whether the cultural conceptions that might make suicide in terminal illness a possible choice in an English-speaking world argue for or against such a role. In examining both the Netherlands and Germany, we see two strikingly different physician roles: one in which the physician responds to the patient's request for euthanasia and it is *only* the physician (not a nurse, family member, or any other person except the patient him- or herself) who may administer the lethal drug, and in which the physician is expected to remain with the patient (and the patient's family) throughout the time it takes for the drug to produce death; the other in which the physician is not consulted, except perhaps to obtain the drug, and in any case is not present while the drug is ingested or the period of dying occurs. Determining what ought to be the role of the physician in the United States, if suicide in terminal illness is to be both morally respected and legally protected, is of course a question of certain practical matters—on the one hand, to exclude the physician seems to preclude the possibility of counseling, confirmation of the diagnosis and prognosis in this context, and physician presence and assistance, perhaps even reassurance, at the time of death; to include the physician seems to bring with it the possibility of paternalism, control, institutional regulation, and potential inflexibility. But it is not only a question of these practicalities, however important they may be. It is also a matter of the fit between persons' conceptions of what they are doing and the structures within which it is possible for them to do it, and this is a much subtler matter indeed.

These are not easy issues to resolve. Worse still, in trying to do so we may find ourselves at an impasse: it is well indeed to look at other cultures for help with our own dilemmas, but doing so also obliges us to recognize our own severe limitations in attempting to resolve them. We may be able to recognize what our problem is: because our language is impoverished in its lexical resources for referring to self-caused death, we are paying the price in increasing social tension over this issue. Yet this insight does not tell us how to resolve our problem. I suspect we will find that while both the Netherlands and Germany can provide profoundly useful lessons (if we are careful to see what they are), neither the Netherlands nor Germany will prove quite the right model for the United States. We can expect to watch ourselves spend the next decade or two developing distinctive, conceptually and culturally fitting aid-in-dying practices of our own.

Acknowledgments

I'd like to thank Sylvia Sauter and Hans Henning Atrott of the Deutsche Gesellschaft für humanes Sterben for various interviews in Berlin and Hamburg, September 1991. I'd also like to thank Ali Wilson for her assistance under the Undergraduate Research Opportunities Program at the University of Utah.

References

1. In the Netherlands, euthanasia remains a violation of statutory law, but the physician who adheres to a careful set of guidelines is protected from prosecution under a series of lower and supreme court decisions.

2. Among the most recent works claiming to find evidence of abuse, see Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (New York: Free Press, 1991), and John Keown's "On Regulating Death" in this issue of the *Hastings Center Report,* both drawing to some extent on the earlier claims of Dutch cardiologist Richard Fenigsen. Such works tend to conflate two issues: whether abuse is actually occurring, and whether there are adequate protections against abuse; within the former category, they also fail to distinguish between procedural abuse (e.g., not following the guidelines) and substantive abuse (killing patients against their will).

3. See my "Seven Caveats Concerning the Discussion of Euthanasia in Holland," *Perspectives in Biology and Medicine* 34, no. 1 (1990): 73-77.

4. These are the findings of the Remmelink Committee report, the first full-scale empirical study of euthanasia in the Netherlands. A summary of the findings in available in English is in P. J. van der Maas, J.J.M. van Delden, L. Pijnenborg, and C.W.N. Looman, "Euthanasia and Other Medical Decisions Concerning the End of Life," *Lancet* 338 (14 September 1991): pp. 669-74.

5. KRC Communications Research, 1991 *Boston Globe*/Harvard Poll; some results published in *Boston Globe,* 3 November 1991.

6. The phrase is former Surgeon General Everett Koop's, used in TV spots in Washington on the eve of the election in November 1991.

7. See Peter Singer, "On Being Silenced in Germany," *The New York Review of Books,* 15 August 1991, pp. 36-42, and Bettina Schöne-Seifert and Klaus-Peter Rippe, "Silencing the Singer: Antibioethics in Germany," *Hastings Center Report* 21 no. 6 (1991): 20-27, for accounts of responses to discussion of euthanasia and other topics. Also see the more comphrensive volume, *Zur Debatte über Euthanasie* [On the debate over euthanasia], ed. Rainer Hegselmann and Reinhard Merkel (Frankfurt: Suhrkamp Verlag, 1991), containing much of the discussion as well as responses to it. An example of the opposition is to be found in Christian Stadler, *Sterbehilfe—gestern und heute* [Aid-in-dying: yesterday and today] (Bonn: Psychiatrie-Verlag, 1991).

8. Personal communication, Karl-Heinz Wehkamp, Director, Sozialmedizinisch-Psychologisches Institute der Evangelisch-Lutherischen Landeskirche Hannovers. Dr. Wehkamp is currently involved with the study at the University of Göttingen, "Ärztliche Entscheidungen in Konfliktsituationen" [Physician decision-making in situations of conflict], which is directed by Hannes Friedrich, Eva Hampel, Klaus Held, Bettina Schöne-Seifert, and Jürgen Wilhelm. The expected completion date for the study is July 1992.

9. See Volker Krey, "Tötung durch Zulassen eines Selbstmordes" [Killing by allowing a suicide to occur"], *Strafrecht Besonderer Teil,* vol. 1, 7th edition (Stuttgart: Verlag W. Kohlhammer, 1972, 1989), pp. 35-37.

10. See Volker Krey, "Euthanasie nach deutschem Strafrecht—Strafrechtliche Probleme der Sterbehilfe für unheilbar Erkrankte" [Euthanasia according to the German criminal law: the problem of aid-in-dying for the terminally ill], in *5. Europäischer Kongress für humanes Sterben,* (Augsburg: Deutsche Gesellschaft für humanes Sterben e.V., 1985), pp. 145-50, and also the previously cited work.

11. See, however, Hermann Pohlmeier, *Selbstmord und Selbstmordverhütung* [Suicide and suicide prevention] (Munich: Urban & Schwartzenberg, 1983) for a discussion of suicide and suicide prevention that also considers the relationship of suicide prevention to issues about freedom to choose suicide; a briefer statement can be found in his editorial, "Suicide and Euthanasia—Special Types of Partner Relationships," *Suicide and Life-Threatening Behavior* 15, no. 2 (1985): 117-23.

12. Personal communication, Hans Hennig Atrott, President, DGHS, 8 January 1992.

13. Derek Humphry, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (Eugene, Oregon: The Hemlock Society, 1991).

14. Personal communication, Derek Humphry, President, The National Hemlock Society, 4 February 1992.

15. See *Der große Duden: Synonymwörterbuch,* 1964, s.v. *Selbstmord.*

16. Considerable critical discussion has been devoted to the issue of whether Werther's death—depicted as resulting a dozen hours after a self-inflicted gunshot wound to the head, clearly involving considerable suffering, is really intended by Goethe as a pure example of *Freitod,* or whether on the contrary it is a parody of it or warning against it. The publication of *The Sorrows of Young Werther* did lead to a rash of copycat suicides among young men, many of whom were dressed in clothing similar to Werther's—a blue waistcoat and a yellow vest.

17. Friedrich Kluge, *Etymologisches Wörterbuch der deutschen Sprache* [Etymological dictionary of the German language], (Berlin: DeGruyter, 1989), p. 231. See also Karl Baumann's remarkable dissertation on the development of the terms *Selbstmord* and *Freitod: Selbstmord und Freitod in sprachlicher und geistesgeschichtlicher Beleuchtung* [Suicide and free death as illuminated by linguistic and intellectual history] (Gießen: Dissertationsdruckerei und Verlag Konrad Triltsch, 1934), which includes extensive personal reflections from other linguists and over 100 responses to a questionnaire about usage of these two terms.

18. Translation Thomas Cannon, Modern Library edition of Nietzsche's *Thus Spake Zarathustra.*

19. The first known occurrence of the single word *Freitod* is dated 1906, some twenty-three years after Nietzsche's *Zarathustra.* See Baumann, *Selbstmord und Freitod,* p. 13.

20. Gabriele Wohmann, in "Auszüge aus der öffentlichen Podiumsdiskussion 'Freiheit zum Tode?'" [Selections from the public panel discussion 'Freedom for Death?'], with Jean Améry and Gabriele Wohmann, in *Selbstmordverhütung: Anmaßung oder Verpflichtung,* ed. Hermann Pohlmeier (Bonn: Keil Verlag, 1978), p. 13.

21. See, for example, the widely discussed proposal for revisions in the law on aid-in-dying, *Alternativentwurf eines Gesetzes über Sterbehilfe* [Alternative draft of a law on aid-in-dying], developed by a working group of professors of criminal law and of medicine (Stuttgart: Georg Thieme Verlag, 1986), and the volume of commentary edited by H. Atrott and H. Pohlmeier, *Sterbehilfe in der Gegenwart* [Aid-in-dying in the present] (Regensburg: Roderer Verlag, 1990).